

MEDICAL AUTHORIZATION

for Make-up Examination

NEW JERSEY DEPARTMENT OF PERSONNEL

Test security is of critical concern in authorizing make-up examinations, thus such authorization is limited by law. Pursuant to N.J.A.C. 4A:4-2.9(a), a request for a make-up examination on medical grounds may only be granted in cases of “[s]erious illness or disability of the candidate on the test date...”

PLEASE PRINT

Return the Completed Form to:

New Jersey Department of Personnel
Information Center Attn: Joan Crenshaw
P.O. Box 310
Trenton, New Jersey 08625-0310

If you have any questions:

Telephone: (609) 292-9467
TDD: (609) 633-3802
FAX: (609) 984-1064

NAME OF CANDIDATE	Social Security Number	TEST DATE
EXAM TITLE	EXAM SYMBOL	
NAME OF PHYSICIAN	PHYSICIAN BUSINESS TELEPHONE ()	
PHYSICIAN ADDRESS _____ _____		

Physician's Diagnosis and Certification

PLEASE PRINT

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<i>(Use additional sheets if necessary)</i>	
When did illness/injury begin? ► _____	Will the candidate be disabled on the test date? <input type="checkbox"/> YES <input type="checkbox"/> NO
Will the candidate be able to take the examination on the test date if the Department of Personnel provides special accommodations such as additional test time, someone to read the examination or mark the answers for the candidate? <input type="checkbox"/> YES <input type="checkbox"/> NO	
What is the earliest date this candidate can take this test? ► _____	<div style="background-color: black; color: white; padding: 5px; text-align: center; font-weight: bold;"> Please note any information regarding your patient's medical condition will be kept STRICTLY CONFIDENTIAL and in a separate file with the Department of Personnel. </div> <div style="padding-top: 10px;"> Signature of Physician: ► _____ Date: ► _____ </div>
<p>I CERTIFY that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me on this form or any additional sheets used are willfully false, I am subject to punishment under penalty of law.</p>	